

# KenSimpler

## STATE TREASURER

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### Caring About the State's Healthcare Plan

Chances are that you have had some meaningful encounter with our healthcare system. I don't mean an annual physical or a one-off trip to an urgent care center. I am talking about a lengthy interaction, over a few months at least, involving multiple doctors and/or specialists. And, if not you personally, you have almost certainly been part of such a process with a loved one.

In my case, I have experienced such episodes of care through each of my parents' bouts with cancer, my wife's episodic migraines and my daughter's diagnosis with Celiac Disease. In all cases, the ultimate outcome has been successful – permanent cure or manageable condition, in each case with a high quality of life. These happy results belie a sometimes bewildering and frustrating process, where waste of both time and resources is all too apparent.

My own, direct experience with healthcare is more benign. I am generally healthy and but for a few mishaps with some power tools, allergic reactions and periodic testing, I have not had occasion to interact meaningfully with our healthcare system as a patient.

I have, however, over the past twenty years “touched” healthcare from other perspectives. I have invested in the managed care industry as an asset manager, studied the economics of health policy as a student of public administration, and served on the finance committee of one of our local healthcare providers. All these experiences taken together add up to me being an informed layperson when it comes to understanding this industry that constitutes almost 1/5<sup>th</sup> of our U.S. economy.

As your State Treasurer, you would not think that it would be incumbent upon me to be a healthcare expert. You would be wrong on at least three bases.

### Why Healthcare is an Area of Concern for Me – And You

First, and most broadly, I am a statewide fiscal officer. In that capacity, it would be negligent of me not to have an understanding of expenditures that total in excess of 30% of our general fund spending (i.e., our \$4 billion operating budget). It's simply too big a use of resources to ignore, even if I do not administer the departments responsible for our healthcare programs.

Second, I am the head of a state agency that hires and employs people; I worry about both their care and their compensation. I want healthy, productive workers who earn a fair and competitive living for the work that they do. Healthcare benefits comprise an ever larger share of the remuneration of my workforce, both as current benefits and as promises of care in retirement – nearly 20% of total compensation. As such a critical component of the employment relationship, care needs to be affordable, accessible and high quality.

Finally, and most directly, I am one of nine members of our State Employee Benefits Committee (SEBC), the body that determines how we design, administer and pay for healthcare for more than 120,000 Delawareans. Yes, you read that figure correctly. Our Group Health Insurance Plan (GHIP) for active state employees, retirees and their dependents covers in excess of 12.5% of our State's population.

Consider that more than half of our 945,000 citizens are either uninsured (70,000) or covered for healthcare by Medicaid (230,000), Medicare (180,000) or other government programs (30,000). Of the remainder in the private and/or commercial market, the GHIP's share is almost 25%! That's the third major part of my concern with how we "do" state healthcare and the reason I apply a considerable amount of my time to my appointment on the SEBC.

When you have at least one quarter of the market share as a buyer, there's a reasonable chance that you are the market. As we consider how to structure healthcare for state employees and retirees, we are indirectly shaping healthcare markets for all Delawareans, directly effecting the delivery system for the half of our population in the commercial insurance markets and very pointedly impacting the 70,000 or so Delaware workers in the healthcare field.

So, whether you are a state employee, healthcare worker, taxpayer or average citizen, what the SEBC does affects you. As a consequence, after 18 months on the job, I wanted to share with you a little bit about this Committee, its composition, recent history and my hope for its direction. Decisions of import are afoot.

#### SEBC and GHIP – A Primer

The SEBC was legislated in 1999 to serve as the policy board for the State's group health plan, a self-insured vehicle that pays for health benefits for employees and retirees of the State and other participating groups like the University of Delaware, City of Dover and the Delaware Solid Waste Authority. Of the 122,000 lives covered under the GHIP, a little more than 100,000 are active employees or retirees not yet eligible for Medicare (i.e., under 65 years of age) and their dependents. The

remaining 20,000 members are covered by Medicare, in addition to which the GHIP provides supplemental insurance.

The composition of the SEBC includes three statewide elected officials (the State Treasurer, the State Insurance Commissioner and the Lieutenant Governor), three of the Governor's Cabinet Secretaries (from the departments of Finance, Health and Social Services and the Office of Management and Budget), the Controller General (who reports to the General Assembly), the Chief Justice of the Courts and a rotating representative from one of the four principal state employee unions (currently Corrections). The Director of the Office of Management and Budget is the chairperson of the committee, and it is his office that is responsible for the administration of the GHIP.

The group plan budget for the current year is \$800 million. Roughly 95% of that amount is used to pay claims and 5% to administer the program (a good expense ratio). As with plans all over the country, the GHIP has been struggling to control plan costs. Both utilization and price levels have been increasing over time, resulting in plan expenses rising by 6% per annum on average over the last decade. That rate of increase is twice the pace at which state revenues rose over the same period, posing a significant fiscal problem, to put it mildly.

Prior to and during my tenure on the SEBC, efforts to reign in costs have consisted of plan design changes aimed at ensuring that healthcare is purchased by participants at the lowest cost provider(s), eliminating coverages that are not commercially standard and pushing for the provision of care in bundles and not à la carte. These methods have been employed by virtually all plan sponsors and nothing the GHIP has done to control costs would be considered outside the ordinary.

Beginning a few months before I took office, however, the GHIP went from an ongoing management problem to a crisis. After a period of unusually low claims experience, resulting in significantly lesser than expected costs, claims soared and plan expenses wiped out nearly \$100 million of the fund's reserve and contingent liability. The length of this newsletter does not allow me to go into the historic management of the fund, but suffice to say that the "emergency" could have been less severe had plan funding increases been steady and the reserve not drawn down to fund predictable price increases.

The rapidity with which the fund's costs exploded required the General Assembly to scramble budget priorities to accommodate the need to finance the plan for Fiscal 2016 (which began on July 1 of last year). The scale of the "surprise" provoked a predictable response. A Task Force was formed to study the issue and make recommendations to the General Assembly. Some forensics were to be engaged and a series of solutions solicited.

The Health Fund Task Force – Precursor to Planning

The Health Fund Task Force (HFTF) began its meetings in September of 2016 and concluded in December of that year. The 12-member panel consisted of four legislators representing both caucuses of each chamber of the General Assembly (i.e., 2 Ds and 2 Rs), four members of the main unions representing plan participants (teachers, troopers, corrections and AFSCME/other) and four members of the SEBC (me, the Insurance Commissioner, the Chief Justice and the Director of OMB). As with the SEBC, the HFTF was chaired by the Budget Director and administered by the staff of the Budget Office.

Notably, the legislation establishing the HFTF required the Office of Management and Budget to hire a consultant not currently retained by the State to assist the Task Force. As a practical matter, this instruction meant that the advisor then engaged to assist the Budget Office with the management of the GHIP could not also serve as the advisor to the HFTF. More about that below.

What ensued over three months were a series of seven meetings – generally 2-3 hours in length – during which HFTF members were “educated” by various outside stakeholders (e.g., consultants, providers, doctors and insurers) as to the state of healthcare markets in Delaware, the economics of the GHIP and the health status of plan participants and Delawareans in general.

Debate during these sessions was sometimes vigorous, but on the whole, the exercise produced little detailed understanding of our problems much less appropriate solutions. The members of the HFTF were effectively healthcare lay people with limited pre-existing knowledge of the intricacies of health plan design and healthcare reform. The amount of information directed at the members was overwhelming and the timetable to assimilate all such information and reach any consensus was too aggressive.

At best, the exercise of the HFTF served as a primer on healthcare in Delaware for the twelve members of the Task Force. Owing to the lack of any clear set of agreed upon conclusions among the members, the HFTF was unable to make any unified recommendations to the SEBC, the Governor or the General Assembly. Rather, the final report of the HFTF serves as a summary of the information presented to the Task Force and articulates a number of “findings.”

To say that the exercise was a waste of time would be too harsh – though you will find members of the HFTF with that opinion. In my view, however, the HFTF was a necessary step in the evolution of a strategic plan for the GHIP. I liken it to the seven stages of grieving.

Whereas the SEBC and the General Assembly had to first grapple with disbelief (how could the GHIP be broke?), express denial (not my fault!) and do some bargaining (we can tinker with this and get through the budget year), the HFTF and its composition provided the vehicle that allowed for expressions of guilt (we made

some mistakes), anger (yes, you did make some mistakes!) and depression (how are we ever going to fix this?).

Upon conclusion of the HFTF, I would like to think that the members (and other stakeholders who participated in the process) are ready to move to the seventh and final stage – acceptance and hope. And there is evidence of both.

#### The Way Ahead – Mission, Goals, Strategies & Tactics

In the first instance, the variety of stakeholders on the HFTF have come to recognize that there is not likely a silver bullet solution to our healthcare problems, and that the costs of resolving them is not going to be hung around the neck of any one, single group – participants, providers or taxpayers.

Moreover, as raucous as some meetings became between representatives of members and industry, the wake of the Task Force process has shown some reconciliation and resolve to work together to see if there is a long-term means of sharing the pains and gains of this exercise. There is, in short, begrudging acceptance that we are all in this together.

In addition, there is hope. Just over the course of the last few meetings, I perceive that there is a greater resolve among members of the SEBC to pick up the Task Force's findings and convert them into an actionable set of recommendations to be implemented by the GHIP. The most cynical observers of how things get done in Dover may disagree, but I see green shoots.

One source of hope lies in the selection of a new, strategic consultant for the GHIP. The SEBC's current consultant has served in support of the Budget Office in a principally administrative role. Conversely, the HFTF consultant was engaged primarily to lead a holistic review of the GHIP and offer forward-looking recommendations, but not aid with plan administration. The most recent hire will serve in both capacities, resulting in what I hope will be greater "ownership" by the consultant of plan performance.

That dual mandate is being put to the test immediately. Begun in June and to be finished by November, the new consultant will have assisted the Budget Office in completing a competitive RFP process to retain third party administrators for the GHIP (i.e., potential replacements for Aetna and/or Highmark). Over the same 6-month period, the consultant will have led the SEBC through the development of an over-arching 3-5 year plan for reform of the GHIP. Given the scale and complexity of these twin undertakings, it won't take us long to know if we've chosen the right horse to ride or if we need to switch out ponies again.

The second basis for hope is that—for the first time in my experience on the SEBC—we are engaging in the development of a comprehensive strategic plan. Concurrence around such a plan will allow Committee members to evaluate if and

how each action of the SEBC, beginning with the selection of vendors under the above-mentioned RFP, fits into the overall framework for GHIP reform.

Befittingly, the initial presentation for development of the strategic plan was, in fact, strategic. The new consultant outlined a process model to develop (i) an overarching mission for the GHIP, (ii) goals that support the mission, (iii) strategies to effect the goals and (iv) tactics to implement the strategies. In each case, the responsibility for the development of these was clearly assigned: the SEBC was to frame the mission and articulate the goals and OMB was to present the SEBC with strategies for approval and then implement the tactics to achieve them.

Significantly, the consultant has encouraged the SEBC to frame its goals in terms that are S.M.A.R.T., an acronym that stands for Specific, Measurable, Attainable, Realistic and Time-bound. This level of discipline has been lacking on the Committee to date and the shift to adopt such rigor augurs for a higher level of performance and measurement of the GHIP.

Finally, there is hope in so far as the SEBC has begun to engage in some introspection. Conversations have occurred among a variety of Committee members as to whether the body is properly constituted, led and organized. Should the public, or at least experts from industry, be represented on the Committee? Can OMB successfully serve as the chair of a body that it also administers? Is the single committee, one meeting per month structure adequate to do all the business of and strategizing for the GHIP?

Production before year-end of a thoughtful, holistic framework for reforming the GHIP would validate the capacity of the SEBC to execute its fundamental purpose. Failure should invite the next Governor and the General Assembly to address the questions posed above and then some.

The “patient” in this case is sick, but not terminal. A proper remedy requires skillful intervention under a thoughtful plan of care, not more palliative treatment.

Let’s hope.

A handwritten signature in blue ink, appearing to be the initials 'Kn' followed by a stylized flourish.